Whereas young girls are often pulled from school and required to fill their lost mother's roles;

Whereas a mother's death lowers family income and productivity which affects the entire community;

Whereas in countries with similar levels of economic development, maternal mortality is highest where women's status is lowest;

Whereas the United States ranks 41st among 171 countries in the latest UN list ranking maternal mortality;

Whereas the overall United States maternal mortality ratio is now 11 deaths per 100,000 live births, one of the highest rates among industrialized nations;

Whereas United States maternal deaths have remained roughly stable since 1982 and have not declined significantly since then;

Whereas the Centers for Disease Control estimates that the true level of United States maternal deaths may be 1.3 to 3 times higher than the reported rate; and

Whereas ethnic and racial disparities in maternal mortality rates persist and in the United States maternal mortality among black women is almost four times the rate among non-Hispanic white women: Now, therefore, be it

Resolved, That the Senate—

(1) makes a stronger commitment to reducing maternal mortality both at home and abroad through greater financial investment and participation in global initiatives; and

(2) recognizes maternal health as a human right.

AMENDMENTS SUBMITTED AND PROPOSED

SA 5088. Mr. DURBIN (for Mr. KENNEDY (for himself and Mr. HATCH)) proposed an amendment to the bill S. 901, to amend the Public Health Service Act to reauthorize the Community Health Centers program, the National Health Service Corps, and rural health care programs.

TEXT OF AMENDMENTS

SA 5088. Mr. DURBIN (for Mr. KENNEDY (for himself and Mr. HATCH)) proposed an amendment to the bill S. 901, to amend the Public Health Service Act to reauthorize the Community Health Centers program, the National Health Service Corps, and rural health care programs; as follows:

In lieu of the matter proposed to be inserted, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Safety Net Act of 2008''.

SEC. 2. COMMUNITY HEALTH CENTERS PROGRAM OF THE PUBLIC HEALTH SERVICE ACT.

(a) ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR THE HEALTH CENTERS PROGRAM OF PUBLIC HEALTH SERVICE ACT.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by amending paragraph (1) to read as follows:

''(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

''(A) $2,065,000,000 for fiscal year 2008;

''(B) $2,313,000,000 for fiscal year 2009;

''(C) $2,602,000,000 for fiscal year 2010;

''(D) $2,940,000,000 for fiscal year 2011; and

''(E) $3,337,000,000 for fiscal year 2012.''.

(b) STUDIES RELATING TO COMMUNITY HEALTH CENTERS.—

(1) DEFINITIONS.—For purposes of this subsection—

(A) the term ''community health center'' means a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b); and

(B) the term ''medically underserved population'' has the meaning given that term in such section 330.

(2) SCHOOL-BASED HEALTH CENTER STUDY.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall issue a study of the economic costs and benefits of school-based health centers and the impact on the health of students of these centers.

(B) CONTENT.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall analyze—

(i) the impact that Federal funding could have on the operation of school-based health centers;

(ii) any cost savings to other Federal programs derived from providing health services in school-based health centers;

(iii) the effect on the Federal Budget and the health of students of providing Federal funds to school-based health centers and clinics, including the result of providing disease prevention and nutrition information;

(iv) the impact of access to health care from school-based health centers in rural or underserved areas; and

(v) other sources of Federal funding for school-based health centers.

(3) HEALTH CARE QUALITY STUDY.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this Act as the ''Secretary''), acting through the Administrator of the Health Resources and Services Administration, and in collaboration with the Agency for Healthcare Research and Quality, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes agency efforts to expand and accelerate quality improvement activities in community health centers.

(B) CONTENT.—The report under subparagraph (A) shall focus on—

(i) Federal efforts, as of the date of enactment of this Act, regarding health care quality in community health centers, including quality data collection, analysis, and reporting requirements;

(ii) identification of effective models for quality improvement in community health centers, which may include models that—

(I) incorporate care coordination, disease management, and other services demonstrated to improve care;

(II) are designed to address multiple, co-occurring diseases and conditions;

(III) improve access to providers through non-traditional means, such as the use of remote monitoring equipment;

(IV) target various medically underserved populations, including uninsured patient populations;

(V) increase access to specialty care, including referrals and diagnostic testing; and

(VI) enhance the use of electronic health records to improve quality;

(iii) efforts to determine how effective quality improvement models may be adapted for implementation by community health centers that vary by size, budget, staffing, services offered, populations served, and other characteristics determined appropriate by the Secretary;

(iv) types of technical assistance and resources provided to community health centers that may facilitate the implementation of quality improvement interventions;

(v) proposed or adopted methodologies for community health center evaluations of quality improvement interventions, including any development of new measures that are tailored to safety-net, community-based providers;

(vi) successful strategies for sustaining quality improvement interventions in the long-term; and

(vii) partnerships with other Federal agencies and private organizations or networks as appropriate, to enhance health care quality in community health centers.

(C) DISSEMINATION.—The Administrator of the Health Resources and Services Administration shall establish a formal mechanism or mechanisms for the ongoing dissemination of agency initiatives, best practices, and other information that may assist health care quality improvement efforts in community health centers.

(4) GAO STUDY ON INTEGRATED HEALTH SYSTEMS MODEL FOR THE DELIVERY OF HEALTH CARE SERVICES TO MEDICALLY UNDERSERVED POPULATIONS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on integrated health system models at not more than 10 sites for the delivery of health care services to medically underserved populations. The study shall include an examination of—

(i) health care delivery models sponsored by public or private non-profit entities that—

(I) integrate primary, specialty, and acute care; and

(II) serve medically underserved populations; and

(ii) such models in rural and urban areas.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subparagraph (A). The report shall include—

(i) an evaluation of the models, as described in subparagraph (A), in—

(I) expanding access to primary and preventive services for medically underserved populations; and

(II) improving care coordination and health outcomes; and

(ii) an assessment of—

(I) challenges encountered by such entities in providing care to medically underserved populations; and

(II) advantages and disadvantages of such models compared to other models of care delivery for medically underserved populations.

SEC. 3. NATIONAL HEALTH SERVICE CORPS.

(a) FUNDING.—

(1) NATIONAL HEALTH SERVICE CORPS PROGRAM.—Section 338(a) of the Public Health Service Act (42 U.S.C. 254k(a)) is amended by striking ''2002 through 2006'' and inserting ''2008 through 2012''.

(2) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended by striking ''appropriated $146,250,000'' and all that follows through the period and inserting the following: ''appropriated—

''(1) for fiscal year 2008, $131,500,000;

''(2) for fiscal year 2009, $143,335,000;

''(3) for fiscal year 2010, $156,235,150;

''(4) for fiscal year 2011, $170,296,310; and

''(5) for fiscal year 2012, $185,622,980.''.

(b) ELIMINATION OF 6-YEAR DEMONSTRATION REQUIREMENT.—Section 332(a)(1) of the Public Health Service Act (42 U.S.C. 254e(a)(1)) is amended by striking ''Not earlier than 6 years'' and all that follows through ''purposes of this section.''.

(c) ASSIGNMENT TO SHORTAGE AREA.—Section 333(a)(1)(D)(ii) of the Public Health